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ABSTRACT

Described is the PASS (Psychoeducational Agency-School System) Project, a collaborative effort between the Metropolitan Nashville Public Schools and the Child Study Center of George Peabody College for Teachers to demonstrate how agency and school system resources may be combined in an integrated service delivery system for learning disabled (LD) students. The intervention approach is explained to combine the three theoretical perspectives of behavioral ecological theory, transactional theory, and developmental theory. The model is reported to involve three major thrusts: expanded and improved educational diagnostic services which assess the child's academic strengths and weaknesses as well as his learning and behavior style; increased parental involvement in diagnostic and placement processes; and individual teacher training and support systems for each teacher involved with LD children. Sections address the following project components: in-project coordination; diagnostic liaison; coordination and interdependence between the agency and school system; selection criteria; number served; reevaluation of LD students already being served; referral process; screening process; diagnostic procedure (which includes assessment, prescription, and observation and baseline); liaison services; benefits of the model; teacher and staff training and the diagnostic battery. A sample diagnostic summary report for a fourth grade student is also given. (SBH)

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Bureau of Education for the Handicapped

# The PASS Model Project

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George Peabody College for Teachers
Nashville, Tennessee

## Administrative Handbook

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Introduction

One of the most perplexing questions facing educators today is that of appropriate procedures for the identification and remediation of learning disabilities. The demand for services and availability of monies in this field has increased greatly within the last ten years. Yet Wepman, et al (1975) suggests, "There is little agreement either in medicine or education on criteria for identifying children with. . . learning disabilities. Because the disabilitites presented by these children are extremely heterogeneous, the search for any commonality. . . has been fruitless".

This confusion may be largely attributed to difficulties in three areas; terminology, definition, and diagnostics. Insight into the controversy regarding terminology is provided by Cruickshank (1972). "In the (LD) literature are more than 40 English terms which essentially all apply to the same child. This issue of variance in nomenclature is in itself a significant barrier to the development of a coherent program. While other fields of disability face the same issue to a lesser extent (for example cerebral palsy, mental retardation, or the gifted) sufficient term utilization is available to obtain a meeting of the minds. In this area (LD), however, not only is there an overabundance of terminology, but there is no common denominator of understanding." There is little doubt that the lack of agreement discussed by Cruickshank increases as one moves from principle to practice in the field of learning disabilities.

While new definitions of LD have been recently suggested, the explanation provided by the President's Advisory Committee on Handicapped Children (1968) is still the most prominent. It states, "Children with learning disabilities exhibit a disorder in one of more of the basic psychological processes involved in understanding or in using spoken or written language. They may be manifested in disorders of listening, thinking, talking, reading, writing, spelling, or arithmetic. They include conditions which have been referred to as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, developmental aphasia, etc. They do not include learning problems which are due primarily to visual, hearing or motor handicaps, to mental retardation, emotional disturbance or to environmental handicaps." It is evident that the globalistic nature of this definition yields little direction for deriving specific diagnostic tools or procedures for discriminating LD children from the larger population.

Even those diagnostic tools most often believed sensitive to the deficiencies of LD children are of uncertain value. Recently such instruments as the Illinois Test of Psycholinguistic Abilities (Kirk, 1968) and Frostig Test of Visual Perception (Frostig, 1964) have been questioned as to their construct validity. The result has been to inject some doubt as to whether these instruments actually assess the abilities they purport to measure.

Related to the diagnostic instruments controversy is an accompanying question regarding the efficacy of programs designed to ameliorate language based academic problems. Hammill and Larsen (1974) suggest that

many language deficiencies are so difficult to ameliorate that they may be impractical focal points for classroom instruction. If these language processes do prove resistent to intervention then some doubt is cast on the efficacy of a language based diagnostic process.

While these controversies (and many others) still rage within the field of LD the demand for public services increases daily. One reaction to this demand has been the establishment of Child Service Demonstration Centers in the area of learning disabilities. These centers, funded under Title VI-G and administered by the Bureau of Education for the Handicapped, are designed to provide models for state and local educational agencies in the development of LD programs within their own region.

One such center is the PASS Project, a collaborative effort between the Metropolitan Nashville Public Schools and the Child Study Center of George Peabody College for Teachers. The relationship between these organizations is evident in the acronym PASS (Psychoeducational Agency-School System) and expresses a major project objective; to demonstrate how agency and school system resources may be combined in an integrated service delivery system.

PASS began operations in July of 1974 uder the direction of Drs. Earl Davis and Paul Dokecki. The project's primary objective has been the establishment of an educational intervention system that would significantly accelerate the learning rate of children described as LD by public school systems while placing these children more centrally within the mainstream of public education. In the two years since its inception PASS has gathered extensive information relating to the efficacy of various educational interventions and the process by which a new program is assimilated into an

ongoing educational organization. These topics and the critical decisions that affect their success constitute the major portion of this manual.

Theoretical Foundations

The PASS Model is an intervention approach which combines three theoretical perspectives: 1) behavioral ecological theory, 2) transactional theory (in John Dewey's sense), and 3) developmental theory. Dokecki and Strain (1973) have commented regarding educational interventions as follows:

> We do not see psychological development and competent functioning . . . as natural, normal, automatic, or usual processes; rather, they are continuing achievements. Cognitive, social, and emotional development (parenting) are viewed as tasks to be mastered, albeit executed differently between and often within members of different racial, cultural, and ethnic groups. These tasks currently require significant personal and environmental resources; they will be even more demanding in the future. Given this view of the human condition, intervention programs can be seen as attempts to develop instrumentalities to assist in actualizing the rights of children in a free society by maximazing the human development and competence of young children and their families. These instrumentalities may involve new strategies or social structures requiring importation of various professionals. . . , or may involve rearranging already existing resources in an ecological recycling fashion (p. 177).

The PASS Model involves both "new strategies or social structures" and "rearranging already existing resources" in that it brings together a community-oriented psychoeducational agency and a school system operating in altered and innovative ways.

Behavioral ecological theory as applied in the PASS Model is an extension of ideas developed at Peabody by Nicholas Hobbs and others in Project Re-Ed (e.g., Hobbs, 1966) and recently extended in the Hobbs directed Project on the Classification of Exceptional Children. Regarding SLD, ecological theory would maintain that regardless of the specific etiology of SLD, the most profitable way of conceptualizing the phenomenon for intervention purposes is as a problem of fit (or match) between a child's behavioral competencies and the demands of key socializing institutions, in this case the school and the family. Subsequent to early and accurate identification of an SLD child, specific appraisal of the child's areas of strength and weakness and of factors in the home and school environment would be carried out. Intervention would involve working with both the child and the environment to achieve a better fit or to balance the system.

Transactionalism is an approach to knowledge developed by John Dewey (see Dewey & Bentley, 1949) which complements ecological theory. In education Jacob Getzels has presented a useful transactional model about which Dokecki, Scanlan, and Strain (1972) have commented:

> Getzels sees education as invlolving four interrelated and transactionally related vectors or subsystems: the school and its expectations, the child and his traits or dispositions, the broader community with its political, economic, and social values, and the narrower community with its local and ethnic values. It seem to us that harmonizing these four perspectives should be the goal of educational programs. . .Just as the implementation of compensatory education failed to fit all children into institiuional expectations,

> so will any subaspect of the Getzels' system without dealing with the entire system (p. 186).

As in the ecological position, therefore, the transactional view cautions against viewing problems such as SLD as belonging exclusively to the child and implies that exclusively child-oriented interventions will be inadequate.

Developmental theory as applied to education is best summarized by the title of a recent Harvard Educational Review article: "Development as the Aim of Education" (Kohlberg & Mayer, 1972). In the PASS Model, the task in dealing with an SLD child is to understand the transactions between his competencies and environmental demand as they have influenced his development. Prescriptive psychoeducational programming takes developmental level into account and the goal is to enhance the cognitive and affective development of the child through working with him and the key people in his world. An orderly sequence of development is assumed to occur when the environment presents appropriate and manageable challenges to the child and his significant others.

It is our view that planned educational interventions should be well grounded in theory and we believe that a combination of ecological, transactional, and developmental theoretical perspectives has educational utility. In addition to theory, however, intervention should be well grounded in practical reality. In planning the PASS Model we have attempted not only to develop a service system which will have demonstrable effects at the R & D site, a feat which itself requires a certain amount of attention to local realities, but also to develop a replicable model with external validity for a variety of communities.

PASS Overview

The PASS Model, developed within the previously mentioned parameters, attempts to provide a more productive match between the child and his ecology. In order to accomplish this task, the model is designed to integrate three vital thrusts into a viable service delivery system: 1) expanded and improved educational diagnostic services which asses the child's academic strengths and weaknesses as well as his learning and behavior style; 2) provision of increased parental involvement in diagnostic and placement processes; and 3) individual teacher training and support system for each teacher involved with SLD children.

Each student designated by a school psychologist as being a candidate for SLD services (based on results of WISC-R and other psychological instruments) as well as those already placed in LD classrooms, is seen in a Diagnostic Classroom for a period of three weeks. Educational assessments, both criterion and norm-referenced, are completed. Observations of behavioral, social, and motivational characteristics are made. Diagnostic Summaries for each child are written and include individualized educational plans.

Parents become involved in the diagnostic process through conferences with the Diagnostic Teacher. All assessment information is explained and suggested home activities are mutually contracted. In addition, parents attend and participate in the placement staffing along with school personnel and designated others.

Liaision personnel provide a support system for both the project and teachers. These personnel, through individual conferences with receiving teachers, explain the individual educational plans, assist in obtaining

and preparing materials, provide training in areas of diagnostic prescriptive teaching as needed, and serve as monitors of the efficacy of diagnostic services and teacher implementation.

All of these elements combine to create more appropriate educational services for SLD children and their families within the local school system.

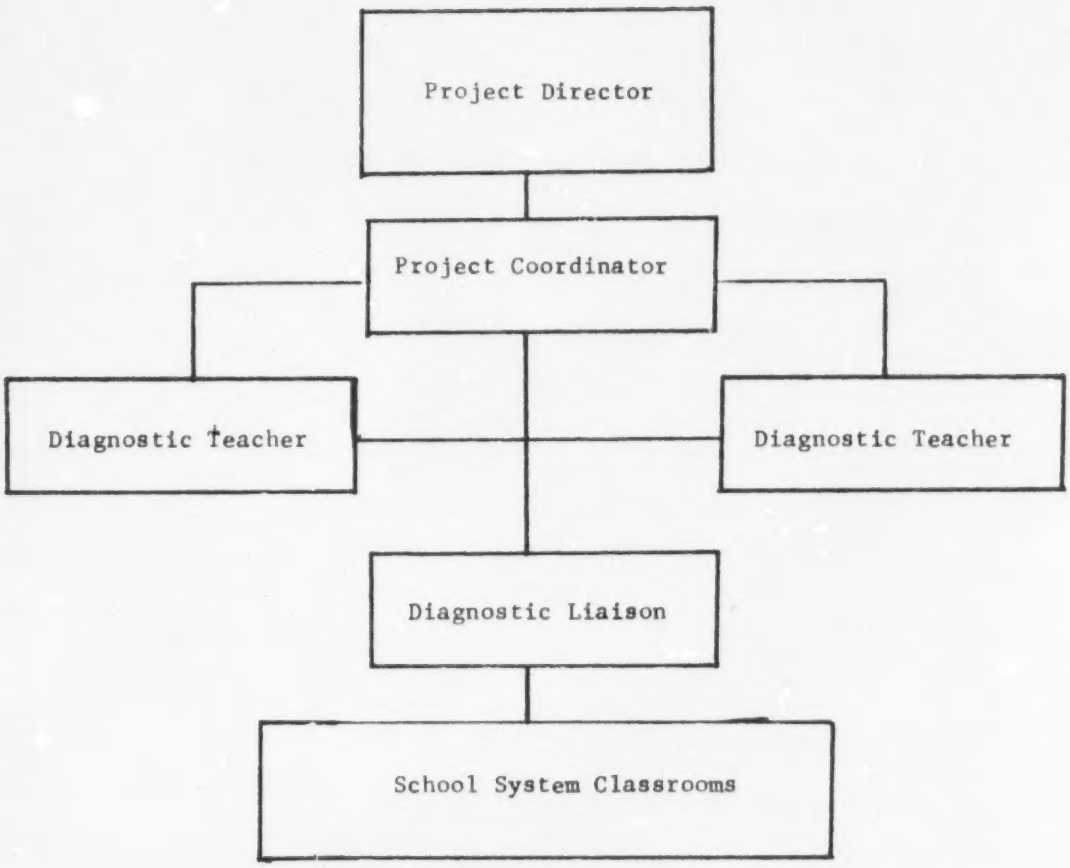
In-Project Coordination

In order to clarify the roles and patterns of coordination within the project, the following job descriptions are provided including each project member's responsibilities (see Figure 1).

Program Coordinator The primary function of the program coordinator is that of organizing and coordinating the service delivery component of the program. The major areas of the service delivery component are diagnostics, teacher training, product development, and the instructional program. It is the responsibility of the program coordinator to develop some basic strategies and guidelines as needed in order to facilitate effective and efficient service delivery to parents and children. In addition, the program coordinator is expected to handle emergency situations as they arise.

The program coordinator is expected to maintain frequent contacts with persons involved in the implementation of liaison and parent training services as well as with those persons in the school system who are involved in providing ancillary services to children. Through these contacts, the coordinator carefully monitors the various components of the service delivery system for the purpose of ongoing evaluation and modification of activities. In order to maximize the impact of the diagnostic teacher

Figure I
PASS Organization



training efforts upon the total program it is necessary for the program coordinator to maintain a working relationship with key persons within the school system and keep them informed of the current status of these services.

The program coordinator is also responsible for basic instructional sequences, assessing innovative procedures, and then providing the vehicle for dissemination of such. He/she also works with the diagnostic teachers and project directors in planning preservice and inservice, and demonstration situations for training purposes.

The program coordinator is directly responsible to the appropriate special services directors and provides detailed feedback regarding the activities of the service delivery system. The program coordinator also participates in the task of mapping out and implementing strategies designed to fulfill overall program goals.

Diagnostic Liaison The diagnostic liaison provides support and training services for classroom teachers who receive students from the diagnostic classroom. The diagnostic liaison conducts one conference with the receiving teacher prior to the child's arrival and at least two conferences thereafter. He/she explains the diagnostic summary report to the classroom teacher, aids in obtaining necessary materials, assists in implementing the educational prescription, and provides individual training for teachers in instructional skills areas. The diagnostic liaison person works closely with the diagnostic teacher in monitoring the efficacy of individual prescriptions and recommending revisions. The diagnostic liaison plays a major role in preparing and presenting in-service training materials. It is further the responsibility of this person to file reports with the project coordinator concerning the effectiveness of the diagnostic summary

report and the teacher's implementation of that prescription.

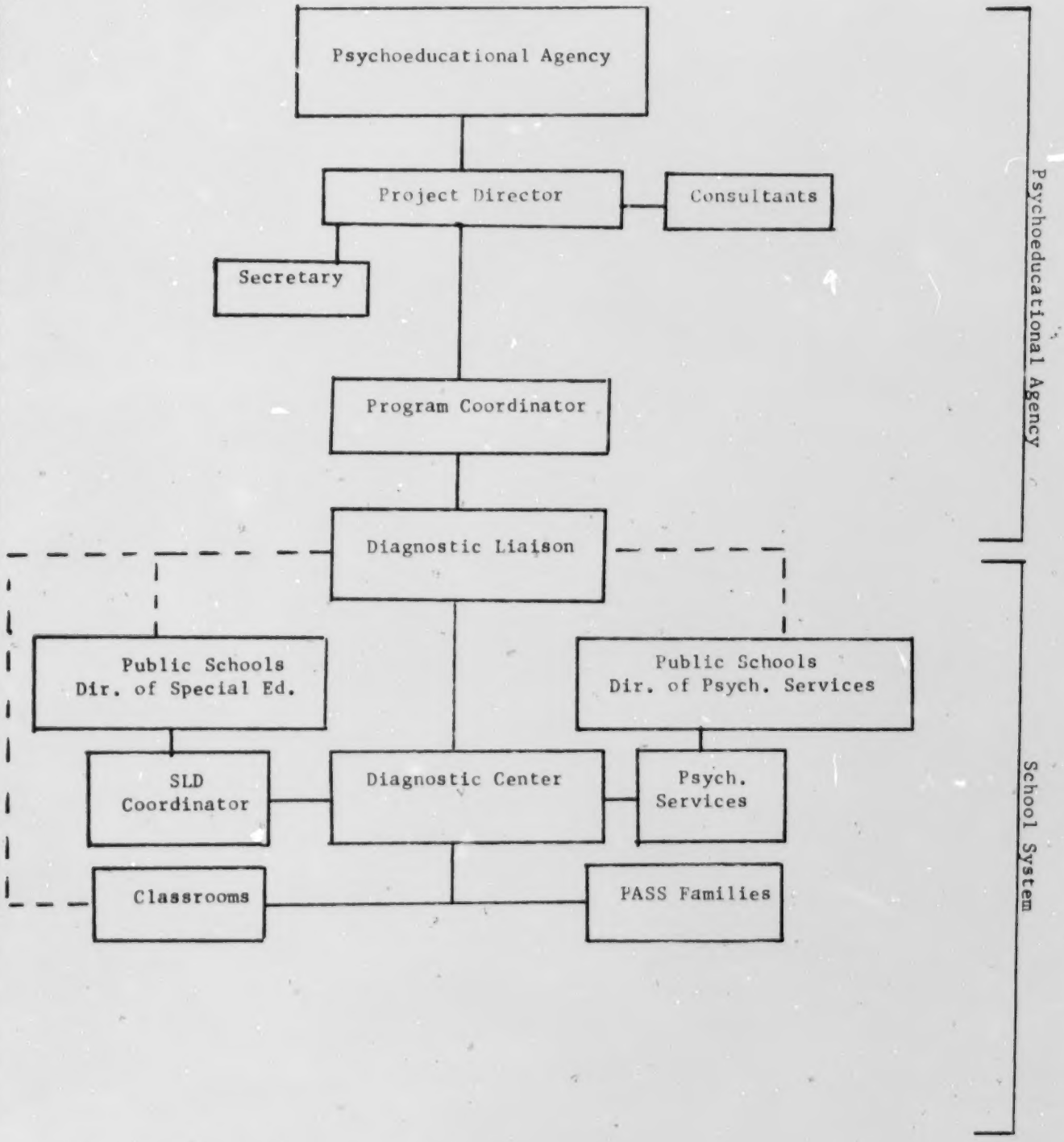
Diagnostic Teacher The primary function of the diagnostic teacher is to assess children's academic, perceptual, behavioral, and motivational strengths and weaknesses through the use of formal and informal tests and observation in the diagnostic classroom. It is the responsibility of the diagnostic teacher to prepare a comprehensive diagnostic summary report on each child assigned to his/her classroom which will include test results, interpretations, and specific recommendations for teachers and parents. It is further the responsibility of the diagnostic teacher to provide a feedback interview for the parents of each child he/she serves. These personnel will be present at all formal staffings for those children placed in the diagnostic classroom. In addition, the diagnostic teacher will play a major role in preparing and implementing in-service training.

Interface

The essence of the PASS Project is the close coordination and interdependence between a psychoeducational agencey (e.g. the Child Study Center) and the school system to improve services for SLD children. School personnel (including teachers, principals, social workers, special education supervisors and psychological services workers) continue to perform their usual function in the referral/assessment process with additional service provided by the project staff (see Figure 2).

The school system will continue to provide the basic referral and screening mechanisms through the efforts of psychological service teams, the supervisor of special education, and school personnel. Educational intervention will be implemented in existing classrooms. The diagnostic

Figure II
Agency-School Interface



center (two diagnostic classrooms) is funded by and under the jurisdiction of the public school system. However, direct support and supervision will also be the responsibility of the project personnel (diagnostic liaison and program coordinator). Additionally, the diagnostic teachers will be considered as operating as part of the PASS Model.

With the guidance of the supervisor of special education, the program coordinator, diagnostic liaisons, and diagnostic teachers will combine their efforts to expand the diagnostic services available to SLD students in the described manner. The liaisons will be connectors between the public schools and the project. Further, the program coordinator will be responsible for maintaining an effective interface between the two services.

Selection Criteria

Children selected for participation in the PASS Model will be encompassed by the following H.E.W. definition of SLD. "The term 'learning disabilities' means those children who have a disorder in one or more of the basic psychological processes involved in understanding or in using language, written or spoken, which disorder may manifest itself in imperfectability to listen, think, speak, read, write, spell, or do mathematical calculations. Such disorders include such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Such terms do not include children who have learning problems which are primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental disadvantage. (P.L. 91-230; 4-13-70)."

Additional specific criteria for selection will be used in the following areas:

Intelligence: Only those students whose WISC-R results indicate a full scale IQ of 75 or above will be considered as being of normal intelligence. This criterion will be considered a guideline as opposed to an absolute cutting point. It is likely that students will be referred who, in the opinion of the psychologist and diagnostic teacher, have IQ scores not indicative of their true capabilities.

Vision: PASS uses as a criterion of visual acuity that of corrected vision no less than 20/40. Students who fall below this visual acuity criterion are eligible for services by vision teachers in many states.

Audition: Corrected bilateral auditory acuity at the 30 decibel level across the critical speech range is a prerequisite for entry into the PASS Model. Children with poorer performance would qualify for services within the speech and hearing department of the public school system. In cases of unilateral loss of audition the diagnostic teacher will judge the student's suitability for placement (Criteria for vision and/or audition will vary across states).

Academics: The PASS Model uses no absolute level of academic deficiency to determine eligibility for placement within the program. The project contends that children should remain in the regular classroom program unless academic ability of the child has dropped from the average classroom performance to the extent that the child's image of himself is endangered by remaining in the regular education program.

Number of Children to be Screened

The number of students screened and/or served through this model will necessarily vary with each site. However, it is reasonable to expect each

diagnostic classroom to serve approximately 50 students during the academic year. Teacher training activities will obviously extend the sphere of influence to more students. It is advisable during the first year for emphasis to be placed on serving, through the diagnostic center, those children already placed in LD classrooms. The following paragraphs provide the rationale for this arrangement.

Reevaluations

The PASS Model may directly serve approximately 50 students per classroom through its diagnostic center during the first year. (Given a large school system) Thirty percent of this number are new referrals while 70 percent are reevaluations of students currently being served. While these percentages may appear disproportionate there are several advantages to this arrangement.

It is likely that 30 percent new referrals will be equal to the openings available within the LD program during one academic year. Only through reevaluation (and possible reassignment) of existing students will the number of placements available increase. This percentage will also insure that within three years all LD students will receive reevaluation and thereafter each child will be reevaluated on an 18 month basis (again, assuming a fairly large school system).

Another advantage of the initial high proportion of reevaluations will be to render more homogeneous the student population served through SLD programs. It is likely that this increased homogeneity will result in decreased teacher difficulties and increases in academic performance. One additional asset of this stragegy is teacher reaction. The strongest

unified request by Metro Nashville LD teachers in recent years has been that of more homogeneous classrooms.

Referral Process

The referral of students for the diagnostic classrooms will be initiated in the established manner by a request for psychological testing from teachers, principals, and/or parents. All children referred throughout the school system are evaluated by the psychological services program. A qualified psychometrist normally assesses the intellectual, academic, emotional, and perceptual competencies of the student. Based on the results of this screening a recommendation for special education services may be made. In the case of students who are of normal intelligence, suitable emotional stability, and who possess obvious academic deficits, a recommendation for SLD may be made. This recommendation will be sent to the special education supervisor who governs staffing and placement for the school district in which the child resides. The supervisor will then contact parents and notify them that their child will be placed in a diagnostic center classroom for a three week period in which his competencies will be further assessed and a judgment of suitability for SLD placement will be made.

Screening Process Overview

The specific activities of the diagnostic classrooms are another section; however, a brief overview will be helpful in understanding the scope of activities involved in the screening process. The three week evaluation is both formal and informal in nature and includes assessments of academic, social, language, behavioral, and perceptual skills.

The diagnostic teacher also evaluates learning procedures, environments, modalities, incentives, and materials to which the student is most responsive.

Based on this information an educational prescription is generated and implemented for the student while he/she is still a member of the diagnostic classroom. The efficacy of the prescription is judged and modifications made where necessary. A final week of implementation of the educational prescription will conclude the student's stay in the diagnostic center.

The student placement decision is made based on diagnostic information from both psychological services and the diagnostic classroom. These placements range from SLD classrooms to varying exceptionalities (VE), resource programs, to regular classroom placements with assistance from a consulting teacher. A conscious effort should be made to place the student in the least restrictive setting possible. In some cases a student will be assessed as inappropriate for any SLD services and returned to psychological services for further evaluation.

Parents are then asked to attend a conference with the diagnostic teacher who explains the results of the evaluation and how this information was used to create their child's educational prescription. They should also receive a set of procedures that may be implemented in the home that will parallel the child's in-class activities.

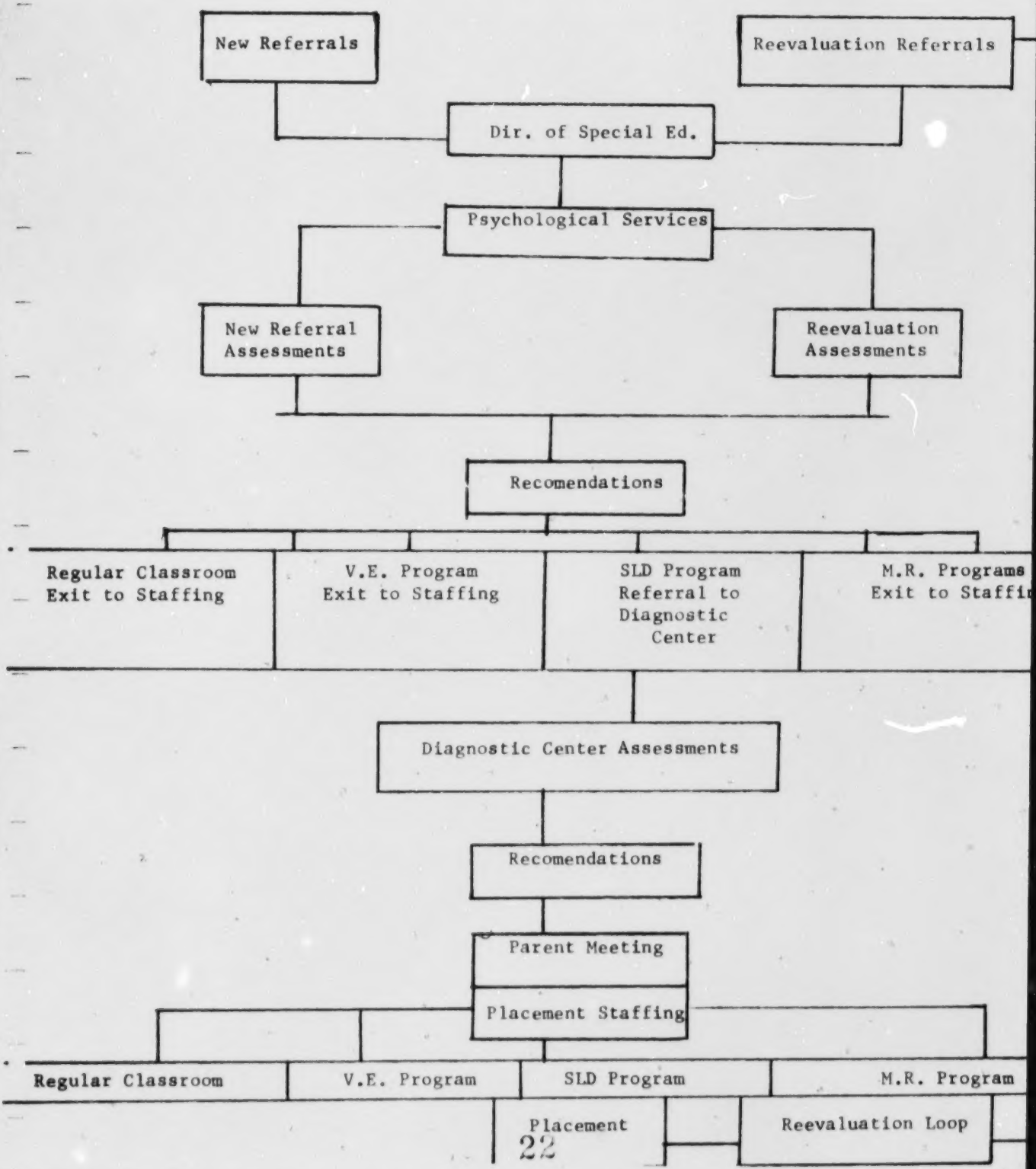
Following this conference, the child undergoes a formal staffing in which placement in a particular program or setting is recommended. This staffing also serves as a vehicle by which to inform parents of their rights under Tennessee Public Law 839, more commonly known as the compensatory

education act. Parents are informed of their right to formal review of the school system's educational placement decision and of the system's responsibility to insure due process in the placement of students in special programs. With parental concurrance the student is assigned a program placement and a date (within 18 months) is set for reentry to the diagnostic center for reevaluation.

The final component of the referral process is the transfer of the educational prescription to the teacher who will be responsible for implementation. This is the responsibility of the diagnostic liaison. He/she visits the receiving teacher prior to the child's arrival. During this visit the educational prescription is explained and needed materials acquired. Two days subsequent to the student's arrival the diagnostic liaison returns to the classroom to assist the teacher in the implementation of the recommended procedures. A third visit should be scheduled one week later. Following this third visit the classroom teacher may request additional consultation (see Figure 3 for referral overview).

Diagnostic liaison personnel serve several purposes in the screening and referral process. Their primary role is that of providing technical assistance to the classroom teacher in the implementation of the educational program. They also serve an evaluative function. Liaison personnel, in conjunction with the classroom teacher, evaluate the efficacy of the prescribed program, and its relevance to the teacher. This information is used by the diagnostic center to evaluate its own effectiveness. A third level of evaluation involves the teacher's completion of a form that indicates those areas in which he/she could use additional training to more

Figure III
Diagnostic and Referral Process



expediently implement the diagnostic center's recommendation. This information is quantified and subsequently becomes the basis for decisions as to future teacher inservice training themes.

As previously stated, this screening and referral process serves new students as well as periodically reevaluating those students previously placed. Within an 18 month period following initial placement complete reevaluation is conducted and all program options are open to the student. In many cases students will return to the regular classroom before the 18 month period expires. When such cases arise the classroom teacher at his/her option may request a conference with the diagnostic liaison to review their recommendations.

This referral and screening system has as its essential feature a longitudinal assessment of student capabilities within a classroom setting. It provides an educational prescription tailored to the student's individual needs and a vehicle by which to monitor the efficacy of the intervention as it is implemented within the school. It is perceived as a system using more comprehensive evaluation procedures than most and directed specifically to the needs of teachers as they receive the student in their classroom. Lastly, the system provides for periodic review of the progress being made by the student and includes assurances that consumers of its products (teachers) play a major role in shaping the service it provides.

Diagnostic Procedure

Each diagnostic classroom consists of one diagnostic teacher, one aide, and five children. The children will rotate through the diagnostic classroom at three week intervals. The diagnostic center is

actually two diagnostic classrooms contained in one centrally located elementary school in the system.

The diagnostic process for each child served will consist of two steps: 1) an initial screening by psychological services and 2) a three week assignment to the diagnostic classroom. Upon referral from the child's current teacher, psychological services is responsible for administering an individual intelligence test and personality assessments, if indicated.

The diagnostic teacher performs both formal and informal evaluations during the child's three week placement in the diagnostic classroom subsequent to services by the psychology staff. All diagnostic data, interpretations, and specific recommendations are then contained in the diagnostic summary report for the use of parents and other professionals prior to and during the placement staffing. The diagnostic summary report is subsequently used as a curriculum guide for the child in the setting deemed most appropriate for him or her.

Psychological services, in every instance, will administer the WISC-R and provide a report of subtest scaled scores, verbal and performance IQ scores. In some cases, personality assessments such as the Children's Appercepton Test and/or the Family Relations Test may be given. Results from individual subtests of the WISC-R yield information on the child's strengths and weaknesses in the basic psychological processes. Each subtest presents a unique task which measures a specific psychological process or set of processes. In considering individual scores and/or patterns of scores, the diagnostic teacher can make initial assumptions concerning the

child's abilities.

Following a synthesis of this information, the child is placed in the diagnostic classroom for a period of three weeks. Normally, five children will be receiving services in each diagnostic classroom at any given time. During this time the diagnostic teacher will further assess the child's abilities, both formally and informally, in academics, language, perception, behavior, and motivation. The diagnostic teachers's evaluation occurs in three phases, each lasting approximately one week.

Phase 1, assessment, consists of the administration of standardized tests and informal criterion checks on specific skills. The formal battery includes academic achievement tests (Peabody Individual Achievement Test, Key Math Test) and perceptual tests (Visual Motor Integration Test, Wepman Test of Auditory Discrimination, Detroit Tests of Learning Aptitudes) ((See "Diagnostic Battery" for more complete description of instruments in diagnostic process)). On the basis of the information obtained, the diagnostic teacher makes decisions about academic skill deficits and the relative strengths and weaknesses in the basic processing areas. Informal assessments are conducted as indicated by the child's needs, in such areas as math fact knowledge and rate, reading rate, phonetic skills, and/or basic sight word knowledge. An audiometric and telebinocular s reening determine acuity levels in hearing and vision. This assessment period can be envisioned as a reduction process wherein more obvious deficits are eliminated as the probable causes of a child's school problems. In addition, all resources of the psychoeducational agency will be available for further diagnosis in the areas of psychology, reading, neuropsychology, and multihandicapped.

Phase II, prescription, necessitates the compilation of all data obtained during Phase I for interpretation and prescription writing. Specific recommendations will be produced for each child on the basis of his/her skills, deficits, and needs. Materials and methods are to be tried and revised, for inclusion in the diagnostic summary. It is also during this period that the diagnostic teacher begins to make decisions about the child's behavioral and motivational characteristics by monitoring his/her reactions to the material and methods presented.

Phase III, observation and baseline, requires a finalization of the diagnostic summary into written form. By observing the child at work in several settings, the teacher determines optimum placement. By combining the two diagnostic classrooms, a small group setting is afforded. Possible short-term placement in a regular classroom within the school provides a large group setting for observation. As the child begins to work under the guidelines of the prescriptive curriculum, the teacher makes assumptions about motivational strategies based on trials conducted in the diagnostic classroom utilizing a hierarchy of motivational techniques from most intrinsic to most extrinsic. Baseline data is taken on appropriate materials and methods that comprise the prescription.

A complete diagnostic summary is written for each child containing test results, interpretations, recommendations for academic programming, behavioral and motivational observations, baseline data, and recomendations for parents. This report is discussed with the parents in an interview held during the last week of the child's placement in the diagnostic classroom. Parental obligations and rights, and school responsibilities are also explained persuant to state and federal legislation.

A staffing is then held to determine proper placement for each child. Parents, teachers, the supervisor of special education and other concerned professionals should be present. The diagnostic summary is explained and the least restrictive environment allowing maximum progress is selected for each child. It seems probable that with detailed diagnostic summaries containing specific, coherent, and relevant recommendations, less restrictive placements may be facilitated than was possible under previous procedures. Existing placement alternatives in most systems include self-contained LD classes, EMR classrooms, resource programs of a wide variety and the regular classroom.

Liaison Services

Follow-up services are provided under the PASS Model by the diagnostic liaison personnel. An initial visit is made to the receiving teacher one week prior to the child's arrival. (There is usually a period of 8-10 days between staffing and actual placement during which transportation is arranged). The diagnostic summary report is explained and necessary materials acquired. Another consultation takes place two days subsequent to the child's arrival to help implement the prescription and facilitate integration into the existing program. A third visit is made by the diagnostic liaison a week later to determine the speed and quality of implementation. Further consultation is to be made available upon the teacher's request. The diagnostic liaison should file a statement with the special education supervisor concerning his/her evaluation of the teacher's implementation of the prescriptive curriculum. A more technical evaluation is to be filed with the project director. The teacher is required to complete an evaluation

of the diagnostic summary he/she receives so that the project's effectiveness can be monitored.

Benefits

In summary, the diagnostic process, as outlined in the PASS Model, is more comprehensive and individualized, provides more relevant information for teachers, and allows more appropriate placement for children than was possible under previous procedures. Diagnosis no longer terminates after the psychologist's two hour evaluation but continues through a three week process of intense, individual assessment conducted by a skilled diagnostician. The diagnostic summary report prepared during the three phases of the child's placement in the diagnostic classroom recomends applicable methods and materials for each child. These procedures can be utilized (with the assistance of the diagnostic liaison person) by any classroom teacher, without regard to previous experience.

Additionally, it is anticipated that this diagnostic process will reduce tne number of false/posttive identifications of SLD children. School personnel are assured of providing the individualized, special program mandated by law. PASS ensures a mechanism for the reevaluation of students currently enrolled in LD classes.

Teacher and Staff Training

A primary responsibility of its operation is the provision of skills to a large number of LD teachers. The substance of these skills are consistent with those earlier formalized by PASS and revolve around assessment, instruction, materials selection, programming, management, and utilization of time.

PASS recomends using the following time line and sequence of events to implement its teacher training program:

During year I the primary responsibility for teacher training falls to diagnostic liaison personnel. They work directly with classroom teachers (not only in SLD, but in all other special program areas) in implementing the educational prescriptions generated by the diagnostic center. This instruction includes reference materials and self-instructional pamphlets in addition to direct classroom training.

A second segment of first year training activities will involve the diagnostic teachers. As has been previously stated, the diagnostic liaison collects information from classroom teachers as to areas of training considered most important. This information becomes the source for presentation topics delivered by the diagnostic teachers at inservice workshops for teachers throughout the year.

While this level of teacher training may not appear substantial, it is important to remember that the potential number of teachers receiving these services is quite large. It is likely that many of the teachers will independently seek out additional information. PASS has as its priority raising the skills level of all teachers involved by a certain degree. This includes, and to some extent is specifically directed toward, those few teachers in every system that are extremely reluctant to alter their teaching procedures.

By year II of PASS all SLD teachers involved will have had at least four students who have been processed by the diagnostic center. In effect, each teacher will have completed 12 training sessions with the diagnostic

liaison as well as participation with the diagnostic teachers during inservice training. At this point teacher training is in a position where the needs and abilities of the SLD teacher have been throughly indexed, and teacher training may become more formal and comprehensive, secure in the knowledge that it will focus on the needs of the classroom teacher.

Second year activities include workshops during all preservice and inservice sessions across the academic year. This will amount to at least five full training days. In addition, one afternoon per month is to be utilized for teacher training.

Another aspect of this training could be the provision of evening classes relating to the skills required in the PASS Model through the special education program at a local college or university. In a state with a continuing education requirement it is likely that teachers will readily respond to this opportunity.

The final phase of second year training will include additional diagnostic liaison personnel. These individuals will continue to be attached to the diagnostic center but will serve a teacher training function throughout the school system. They will assume primary responsibility for teacher inservice training function throughout the school system. They will rotate across all classrooms on a scheduled basis providing additional training within the teacher's own room.

In year III, local teacher training willbecome the primary responsibility of the public school system. Assurances must be secured that positions currently under PASS funding will become a part of the school

system budget insuring continuity of services despite the withdrawal of outside funding. These personnel will carry into the system several years of teacher training experience as well as the plethora of instructional materials and devices developed by PASS. More importantly, by then they will also be familiar with the PASS instructional materials and and processes by which to evaluate new areas of concern on the part of classroom teachers as well as judge the effectiveness of present training activities.

This system of teacher training is based on the belief that permanent educational progress is an evolutionary rather than revolutionary process. It must be perceived as being of value by its recipients, it must occur in the environment in which it is to be applied, and it must decrease rather than increase the variance in educational skills across a large group of teachers. It must allow for consumer input as to its procedures and directions and most improtantly be perceived by the teacher as a system that will provide an opportunity to increase his/her professional capabilities within the realities of today's public educational system.

Diagnostic Battery

The minimum battery of test used in the diagnostic process are described below with sample interpretations. Following this section is an exemplary Diagnostic Summary Report comparable to that which will be prepared for each child in the diagnostic classroom.

The Wechsler Intelligence Scale for Children-Revised (WISC-R) is an individually administered test of the basic psychological processes with ten basic and two optional subtests. Scaled scores will be reported

for each subtest as will Performance and Verbal IQ. Each subtest measures a specific process or set of processes. By considering a child's pattern of scores, the teacher will make initial assumptions about the strengths and weaknesses of that child's abilities. For example, significantly low scores in Vocabulary, Information, and Comprehension would indicate a lack of acquired knowledge which may lower reading comprehension. A low score in Picture Completion indicates poor attention to detail which may prevent the child from discriminating similar words (dig and dog), letters (p and q), or math symbols (4+3, 4-3). Obviously, poor word attack skills and/or spelling would result. Poor performances on Block Design, Object Assembly, and Mazes suggest deficiencies in spatial relations, relating parts to wholes, or math concepts.

Grouping the subtests into Verbal and Performance IQ's provides a second type of information, i.e. probable modality preference. A significant discrepancy between Verbal and Performance occurs when a set of basic psychological processes or the products of these processes are deficient. Therefore, by equating the Verbal IQ score with auditory-vocal skills, and Performance IQ score with visual-motor skills, the diagnostician is able to make some assumptions concerning the child's preferred modality of learning.

Following the initial screening by psychological services, those children who exhibit normal or above average intelligence, emotional stability, and academic deficits will be assigned to the diagnostic classroom for further assessment. This diagnostic process will be divided into three periods: Assessment, Prescription Writing, Observation and Baseline.

During the Assessment week, formal and informal evaluations will be conducted by the diagnostic teacher. Formal instruments which will be used include segments of the following: Peabody Individual Achievement Test (PIAT) by Dunn & Markwardt, Wide Range Achievement Test (WRAT) by Jastak & Jastak, Visual Motor Integration Test (VMI) by Berry and Buktenica, Wepman Test of Auditory Discrimination by Wepman, and the Detroit Tests of Learning Aptitudes by Bijou. In addition, the audiometer and the telebinocular are administered.

The PIAT is an individually administered test of academic achievement consisting of five subtests: Mathematics, Reading Recognition, Reading Comprehension, Spelling and General Information. The Math subtest is a sampling of basic concepts and skills wherein the primary stimulus is oral and requires the child to select a response from four visually presented answers. Reading Recognition begins with visual discrimination exercises and quickly proceeds to a sampling of oral reading of unrelated words. Reading Comprehension requires the child to read a passage silently, and select from four similar pictures the one that best depicts what he has read. The Spelling subtest begins with pure visual discrimination exercises, requires some letter naming, then proceeds to stimulus words presented orally, and the child must select the correct response from four visually presented, phonetically correct spellings. The General Information subtest is similar in nature to the Vocabulary, Information, and Comprehension subtests of the WISC-R and, therefore, need not be given by the diagnostic teacher. The omission of this last subtest of the PIAT will shorten the time required for

administration but will eliminate the possibility of obtaining a total test score. However, since the total test score is merely an average of all the subtest scores and represents no real skill level in and of itself, this statistic is not a meaningful addition to the diagnostic battery.

The WRAT is a group administered test of academic functioning consisting of three subtests: Arithmetic, Spelling, and Reading. The Arithmetic portion of the WRAT is a time test of written computational skills in two levels. Level I, is intended for children up to ten years of age. Level II is for older children and adults. In this diagnostic process, however, only Level I will be administered so that a larger sampling of behavior will be obtainéd at the lower of the skills range, and the tests will be untimed. The information gathered from this rather unorthodox administration will be used solely for clinical diagnostic purposes. The Spelling subtest is similar in format to the traditional spelling tests given in regular classrooms. A word is presented orally which the child must write with no visual cues. Again, Level I will be administered, regardless of the child's age, to obtain a larger sampling of behavior. The Reading subtest is not administered as it is almost identical to the Reading Recognition subtest of the PIAT in format and skills sampled.

The PIAT and WRAT are both administered to each child because of the different approach each takes in testing certain academic skill areas. A comparison of the standard scores obtained in each parallel subtest will yield valuable diagnostic information. For example, a higher score

on the PIAT Spelling than on the WRAT Spelling would suggest a reliance on visual memory rather than auditory discrimination and memory in learning to spell new words. All test scores gathered here will be interpreted in light of the test's format and the nature of the child's response.

The VMI is a test of visual perception and the integration of those skills with motoric output. It consists of visually presented gestalts which the child must copy. This test will be used as an additional check on data obtained from the tests mentioned above and will serve to help determine the child's most advantageous modality for learning.

The Wepman requires the oral presentation of forty pairs of words. Ten pairs are identical and used as validity checks while thirty pairs have variances on one phoneme. The child states that the pairs are the "same" or " different". Auditory discrimination skills as applied to language sounds are thus assessed. The Wepman score is interpreted in conjunction with the VMI and Detroit to determine perceptual preferences.

The Detroit consists of a group of nineteen subtests which measure various perceptual skills in both the auditory and visual channels. For the purposes of the diagnostic classroom, only those subtests deemed most relevant to academic and language skills will be administered. These seven subtests are: Verbal Opposites, Auditory Attention Span for Unrelated Words, Visual Attention Span for Objects, Visual Attention Span for Letters, Auditory Attention Span for Related Words, Disarragned Pictures, and Oral Directions. A profile of the age-equivalent scores will be the basis for assumptions concerning preferred modality and specific perceptual skills such as auditory and visual memory, spatial relations, or auditory association.

The results of all the preceding tests will form the foundation of the assessment performed in the diagnostic classroom. Informal evaluations will continue throughout the three week period and will vary greatly among individuals as the need arises.

Sample Diagnostic Summary Report

CLIENT: Roger AGE: 9-8 b.d. 6-19-66

GRADE: 4th SCHOOL: SEX: Male

BACKGROUND INFORMATION

Roger is reported to be experiencing academic difficulties in areas which require reading and spelling. He has previously been involved in a reading resource room, after school tutoring, and summer tutorial programs. Roger was seen by -------- at the Reading Center ---------- State University on--------. At that time his Slosson IQ was reported to be in the average range. On 12-8-69 he achieved and IQ score of 118 on the Otis- Lennon.

TEST ADMINISTERED

Wechsler Intelligence Scale for Children-Revised

BEHAVIORAL OBSERVATIONS

Roger was pleasant and cooperative throughout testing. He said that he was slightly nervous. Roger was very throghtful in responding to questions requiring a verbal response. He appeared to formulate his answers very carefully before he spoke, choosing his words precisely.

TEST DATA AND INTERPRETATION

Verbal IQ: 118

Performance IQ: 102

Full Scale IQ: 112

| Verbal Tests | Scaled Scores | Performance Tests | Scaled Sco |
|---|---|---|---|
| Information | 14 | Picture Completion | 12 |
| Similarities | 16 | Picture Arrangement | 11 |
| Arithmetic | 5 | Block Design | 8 |
| Vocabulary | 14 | Object Assembly | 12 |
| Comprehension | 16 | Coding | 9 |

Roger's Full Scale IQ of 112 indicates that he is currently functioning in the high average range of intelligence. A discrepancy of 16 points between Verbal and Performance IQ's is significant. The quality of responses on Verbal subtests was high and showed an excellent ability to explain concepts in abstract terms.

Analysis of Verbal subtests indicates that scaled scores are above average in all areas except Arithmetic. An Arithmetic scaled score of 5 is well below average for Roger, suggesting skill descrepancies in this area. Similarities and Comprehension scaled scores of 16 are two standard deviations above the mean. Roger demonstrated a good backgroud of word knowledge and general information about his environment. In addition, his understanding of abstract relationships (Similarities) is excellent.

Performance subtest scaled scores range from a low of 8 on Block Design to a high of 12 on Picture Completion and Object Assembly. All Performance subtest scaled scores are within average limits in terms of chronological age expectancy. Roger's scaled score on Block Design would have been slightly higher, but two designs were completed after the time limit, thus receiving no credit.

In general, Performance scaled scores indicate that Roger is able to visually discriminate fine detail and synthesize parts into meaningful wholes at an average level. He executed Performance items systematically and showed good organizational skills, although he reported being less sure of himself of these items than on Verbal items. The only significantly low score on the entire test occurred in Arithmetic. All other scaled scores do not reflect significant deviations from the mean in a negative direction, although the examiner observed and Roger said, that verbal items were easier for him and that he felt more at ease when asked to answer items verbally.

Roger's Full Scale IQ of 112 indicates current intellectual functioning in the high average range. All Verbal and Performance scaled scores are within average limits in terms of expectancy except in the area of Arithmetic. A scaled score of 5 on the Arithmetic subtest is discrepant from other scaled scores and suggests deficiencies in specific skills. It is recommended that Roger's current level of academic functioning be assessed with an emphasis on identification of strengths and weaknesses in the specific skill areas of reading and math. Roger's understanding of words and concepts is well above average for a boy of his age and it is important to fully explore his level of skill development and whether or not it is discrepant from his level of comprehension in the verbal areas.

TESTS ADMINISTERED

PIAT and WRAT

TEST RESULTS

| PIAT Subtests | Grade Equiv. | WRAT Subtests | Grade Equiv. |
|---|---|---|---|
| Mathematics | 4.7 | Arithmetic | 2.4 |
| Reading Recognition | 1.2 | Spelling | 3.9 |
| Reading Comprehension | 3.9 | | |
| Spelling | 1.4 | | |

It was evident in the Reading Comprehension subtest, that Roger was using context and/or picture clues to get meanings of words. Therefore, it may be assumed that Roger's actual reading ability is much lower than indicated. In reviewing incorrect responses on the PIAT's Reading Recognition and Spelling, it was noted that most were of a type that indicated poor visual memory. The WRAT Spelling, while much higher than the PIAT's Spelling showed errors of the same type. In addition, it was evident that Roger had not remembered some sounds within words, omitting entire syllables in the more difficult words. In general, spelling seems to be easier for Roger when there are no confusing visual stimuli and when words are presented slowly and repeated. The PIAT Mathematics revealed no concept deficits but the WRAT Arithmetic showed marked deficits in computational skills with many careless errors.

TEST ADMINISTERED

Detroit Tests of Learning Aptitude-selected subtests

TEST RESULTS AND INTERPRETATION

| Test No. | Test | Age Equivalent |
|---|---|---|
| 4 | Verbal Opposites | 12-6 |

| Test No. | Test | Age Equivalent |
|---|---|---|
| 18 | Oral Directions | 8-4 |
| 13 | Auditory Attention Span Related Words | 7-4 |
| 9 | Visual Attention Span for Objects | 7-1 |
| 16 | Visual Attention Span for Letters | 6-1 |
| 6 | Auditory Attention Span for Unrelated Words | 4-10 |

Roger performed within expected limits on all subtests except those requiring short-term memory ability. Roger demonstrated a distinct difficulty with memory items as the length increased. That is, as he was given more and more words, letters, or objects, he could recall fewer and fewer. What is sometimes called "overloading" seemed to be occuring, and Roger's statements about his learning problems seem to lend some credence to this supposition. The larger the body of information presented to Roger within a short period of time, the less likely he is to retain any of it. It is also possible that continuous academic work (i.e. without periodic resting periods) may overload Roger and cause him not to be able to attend to the task. It would seem that, according to this and other test data, the above mentioned areas are Roger's only major learning deficits-poor short term memory and a tendency tooverload and "reject" bulks of input.

A short period of diagnostic spelling instruction reemphasized Roger's need for small bits of information. Two rather long words were taught individually to Roger during a five minute period. The first word was mastered (three consecutive correct responses) before the second one was

introduced. Roger could correctly spell both words when dictated one at a time. However, when the examiner dictated both words in rapid succession, Roger mixed parts of both words into one word.

TESTS ADMINISTERED

Keystone Visual Survey

Audiometer

TEST RESULTS

Roger had no difficulties with any section of the visual screening. On the audiometer, his performance was within normal limits. Therefore, vision and hearing acuity were not a problem.

TESTS ADMINISTERED

Informal battery to test written expression

Wepman Test of Auditory Discrimination

GENERAL OBSERVATIONS

The informal battery consisted of the administration of two sets of questions directly related to two silent reading passages for the Spache Diagnostic Reading Scale and two sets of questions from oral reading passages, also from the Spache. A creative writing passage was administered. In addition, Roger was required to write from a recorded passage which he dictated. Writing was not a pleasant task for Roger as he is aware of his inadequacies in this area. He was a bit apprehensive at the start of the testing, but he relaxed as testing progressed.

INTERPRETATIONS

Roger successfully answered each question in terms of content. He was

instructed to use complete sentences. However, the majority of his responses were clauses rather than sentences. This was also a problem in his creative writing. There were a variety of grammatical (plurals, past tense) and punctuation (addition and omissions) errors. The most significant errors were due to spelling difficulties. Roger used a phonetic approach when spelling. However, he confused vowel sounds and the "soft c and s". Syllables and sounds were omitted. There were no significant differences in his performance on the six tasks. The Wepman indicated Roger had difficulty discriminating f, th, v and s. The creative writing passages showed that Roger was able to properly sequence his ideas.

TEST ADMINISTERED

Piers-Harris Children's Self-Concept Scale

TEST RESULTS

Roger's score fell within the normal range.

OBSERVATIONS

Roger was very cooperative throughout the testing session. He asked for the clarification of meanings of words such as "happy", "sad", and "strong". He questioned whether his responses should be based on his opinion or others' opinion of him. The examiner considers this to be an accurate assessment of his self-concept.

DIAGNOSTIC SUMMARY

Roger performed in the high average range on the WISC-R. The PIAT was administered to determine his grade level in the areas of mathematics, spelling, reading recognition, reading comprehension, and general infor-

mation. On the mathematics and general information subtests he was above grade level. He showed weaknesses in reading recognition and spelling. Formal and informal reading assessments were given, indicating problems in phonics, spelling and spontaneous writing. Several substests of the Detroit Test for Learning Aptitudes were administered. These results indicated difficulties in the areas of visual and auditory short-term memory. A self-concept scale was given. The score was well within the normal range, indicating that Roger has no self-concept problems.

RECOMMENDATIONS

In order for Roger to perform up to his academic potential, some special methods and materials should be employed to teach new material. An attempt can also be made, simultaneously, to remediate the memory and overloading problems by slowly building a higher tolerance for parcels of new information. The following suggestions are made.

1. In studying at home or in school, Roger should maintain a schedule of short study periods (15-20 minutes each) separated by quiet rest or "processing" periods (5-10 minutes each).
2. Roger should not do any last minute cramming.
3. To retain class lecture material, it may be helpful for Roger to record the lesson and listen to it again a bit at a time.
4. When studying for a spelling test, practice should be given in writing the word (with little emphasis on oral spelling) since Roger's task at school will be to write the words. Also, it may be helpful for someone to pronounce the word to be spelled slowly by

syllables, instead of as a whole. Gradually, this fragmenting of words can be phased out in favor of entire word pronunciation.

5. In order to increase Roger's visual memory ability, the following exercises are suggested:

a) Spelling words may be put on flash cards for drill. Initially, cards should be exposed for two seconds per letter, but over a period of several weeks, the time should be decreased. This exercise should be done in addition to the written exercise for learning his spelling words and should be aimed at increasing visual memory.

b) Worksheets of words with missing letters can be given to Roger. The teacher should dictate the words slowly, with Roger filling in the missing letters. At first, one letter should be left out; then, increase to all blank spaces.

c) Exercises should be provided with serveral versions of a word: one correct spelling and another with letters out of place.

Example count cuont coutn

6. When writing reports for social studies or reading, Roger should be assisted in the following procedure:

a) Write key words of points to be covered.

b) Compile simple outline from those key words.

c) Expand outline to include minutest points in sentence form.

d) Compose report from outline, embellishing where necessary.

7. Several spelling and language programs may prove helpful in the resource room. These are:

a) Score 1-6 by Weekly Reader (Reading Success Series) teaches sight ru rules for phonics

a) Score 1-6 by Weekly Reader (Reading Success Series) teaches sight rules for phonics and syllabication.

b) Solving Language Difficulties teaches 6 basic spelling rules for different types of syllables.

c) Auditory Perception Training Specifically the sections on memory.

d) Sound Foundations Spelling cards with word patterns.

8. Activities that can be carried out in the home are as follows:

a) Parents should frequently give Roger verbal directions to follow. These should, initially, contain 1 or 2 things to do, such as, "Look in the top dresser drawer in the left-hand side and get my blue scarf." The number of items to be remembered should be gradually increased.

b) Crossword puzzle books should be purchased at dime stores or book stores for Roger to complete.

9. Simple crossword puzzles and seek-a-word puzzles may be used as free time activities.

10. There are several commercially available games which can be fun and instructive at the same time. These could be used at home or in the resource room.

a) Scrabble

b) Concentration

c) Jeopardy

d) Recall

e) Chess

f) Stratego

11. The Dolch 220 Basic Sight Vocabulary words should be taught in the manner mentioned above. A complete list and grid for data keeping are provided.

12. Correct and error rate in reading should be kept daily on the data sheet provided. This can probably be accomplished in the Sullivan Storybooks at first. Increases in correct rate can be rewarded by praise.

13. The Sullivan Programmed Reading Program seems to fit Roger's needs He has been tested and placed in book three.

14. Math facts should be drilled at school as well as at home through the use of the math fact sheets provided. These sheets are divided into 6 catagories- add, carry, subtract, borrow, multiplication, division. Proficiency rate is 25 per minute correct. Roger's current rates are provided.

15. Audio-tape and worksheet drills on vowel sounds should be given immediately, beginning with long vowel sounds. When these are mastered, short vowel sounds may be taught. Materials appropriate for this task are "Short Vowel Sounds" by DLM, "Phonics Cards-Vowels" by Ideal, and Continental Press Materials.

16. Roger works well for praise and recognition awards.

17. It seems most appropriate for Roger to be placed in a regular classroom with assistance by a resource teacher two hours per day. He can work independently and in large groups.

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